of the State Legislature. It would seem gracious on his part to accept the will of the representatives of the people of California and bestow a blessing at the burial of such proposals.

## Annual Session—1949

Completion of the Association's 1949 Annual Session—the seventy-eighth in ninety-three years of organization — marked another milestone in the progress of California medicine and taught two lessons. First, that a topflight scientific program can be developed on the base of our own intrastate medical knowledge plus a careful selection of guest speakers; second, that the Association has grown to such a size that added meeting facilities must be sought.

The Annual Session attracted an unusually large number of sound scientific papers, drew a large number of technical and a smaller number of scientific exhibitors, focused public attention for a few days at least on the progress of medical practice and, all in all, provided a meeting place for friends and colleagues on a personal as well as medical basis.

On the scientific side, numerous complimentary remarks have already been heard as to the high quality of the material presented. The Committee on Scientific Work, after months of planning, brought forth a program which was accorded a splendid recognition by those at the meeting. The very overflowing of meeting rooms attested the quality of the papers. Section officers complained only about the inadequacy of the rooms available to them.

On the business side, the House of Delegates, operating with four reference committees instead of three as heretofore, moved swiftly through its deliberations, held elections and installations and paid homage to physicians who have been members of the Association for fifty years or more. The House of Delegates was the largest the Association ever assembled—recognition of the growth of the organization.

As to meeting quarters, the 1949 session fairly burst at the seams. Even the largest meeting room was barely adequate for the number who attended and the smaller rooms were filled to overflowing and to the point where one section chairman complained that a number of members left the meeting because they became tired of standing in the outside hallway. The session utilized every available public room in a large hotel, plus a neighboring theatre and two large rooms in a nearby auditorium building. Even with this space available, meeting quarters were inadequate.

These overflowing crowds bring to mind the fact that the Association has increased rapidly in size in recent years and that new records in Annual Session attendance are on the way. The registration this year topped 3,600 persons and for next year and the years to come will doubtless go higher. In earlier times there were various hotels available to meet the requirements of a smaller membership and a lesser number of specialty section meetings. Now, with an increased membership and an augmented state population, new horizons appear and must be conquered.

Two possible solutions to this problem come to mind at this time. One, that fewer sectional and more general meetings be arranged, so that the advanced knowledge of the specialists may be made available to the general practitioners and to specialists in other fields whose problems cross specialty lines. Second, that public auditoriums be sought for the holding of meetings, so that a large attendance may be accommodated and the information offered may be made available to all who would listen. This might do away with the more intimate practice of concentrating all session activities under one roof but it would certainly guarantee an adequacy of space for the larger number of members who turn out each year in quest of information and knowledge.

The Council of the Association has voted to hold the 1950 Annual Session in San Diego, where large public buildings will be available. This is a departure from earlier practices but we hope it will prove to be a beneficial move, geared to present and potential needs.

## Industrial Fees—What Next?

Since early last year the California Medical Association has been striving to bring about the adoption of a schedule of fees for industrial injury cases that would be fair to the injured employee, the employer and the physician. However, numerous obstacles have been encountered and this goal is still distant.

The Association published its own recommended fee schedule early in 1949 and suggested that it be put into effect by all members. The insurance carriers countered by agreeing among themselves not to pay these recommended fees. The Association continued to recommend that such fees be considered fair and equitable and great confusion has arisen in billing for professional services at one figure and collecting, in some instances, at another. To the everlasting credit of many insurance carriers and many self-insurors, the fees set by the Association have been considered fair and equitable and have been paid without question. These people agree that the professional man is the best qualified individual to pass upon the fairness of fees for professional services.

More recently a committee of the Association's has been meeting with a committee representing a large group of insurance carriers and has attempted to arrive at a schedule which may be mutually acceptable. At this writing such a schedule has not been produced but hope springs eternal and this objective must not be discounted completely. At least, discussions have been held and some signs of progress have been seen.

If the movement to work out an amicable settlement should fail and the deadline of June 30, 1949, set by the Industrial Accident Commission should arrive, the prognosis is for complete chaos and, undoubtedly, a further effort at chiseling and fee-shopping by some insurance carriers. Members of the Association will be kept advised of all developments in this field and advised of any official decisions by the governing bodies of the Association. Right now, our fingers are crossed.

# Letters to the Editor . . .

## Let's Look at the Health Map

During the first decade of this century the doctors looked at the medical schools. The result of this long look was not only a Council on Medical Education and Hospitals and a survey of medical schools but a decline from 162, an all-time high, to 62, an all-time low in 1930, of four-year medical schools. Thus was eliminated a large number of schools of poor standards, inadequate training, and precarious financing.

On April 2 the Commonwealth Fund released the published report on "The Study of Child Health Services and Pediatric Education." This volume of 270 pages is the compiled work of practically every physician and dentist in the United States. The numerous maps, graphs, and charts depict graphically the status of health services and pediatric education in this country. It represents a herculean piece of work, and many people have said and are saying, "Another survey to be shelved." However, this need not be the case; instead it is and should be another evidence of doctors looking at themselves and the gaps in their work at a time when medicine is progressing at a rapid pace and when the entire world is looking to American medicine as the answer to its own problems. This study well might denote the half-way mark of the century, the first decade of which represents American doctors' first critical look at their system, and it can be the basis upon which doctors now chart the course to be taken in order to extend to all our people the benefits of modern health practice in the best American fashion.

The original promoters of the move in the Academy of Pediatrics to study the child health services in the United States premised this need with four main factors as the reason why children do not receive the desirable preventive and curative care compatible with present standards of pediatric practice. These were: (1) The parents are unable to pay for such services. (2) There is an unwillingness to use, or lack of knowledge of, the available facilities. (3) Services are not available wherever children live. (4) There are not enough physicians well trained in the medical care and supervision of children in all areas.

The study provides the graphic answers to these posed problems. There is a definite correlation between income and services, there is a mal-distribution of both facilities and personnel. There are discrepancies in training and the work required of physicians when they enter practice. There are also many somewhat surprising revelations in the study. Thus the supposedly vanishing general practitioners constitute two-thirds of the physicians practicing in the United States. The study reveals that the family physician carries three-fourths of the total burden of child care and one-third of his practice is devoted to children. Medical education is not oriented to train these physicians so that they are equipped to meet the type of practice that the community imposes upon them. Of the physicians graduating from medical schools almost half of the general practitioners have had little hospital training in pediatrics before entering practice. Thirty-five per cent have had one month or more hospital training in pediatrics, 33 per cent have had less than one year hospital training of any kind, and 32 per cent have less than one month's hospital training in pediatrics.

Another surprising revelation (and it should allay some of the fears of antagonists) is the extremely small volume of medical care provided by community health centers and clinics as compared with the great volume carried by private physicians and especially the general practitioner. Furthermore, although government public health clinics and conferences should fill the economic gaps in the health program, they in general follow the same pattern of aggregation in heavily populated areas as do the rest of medical services.

Official comments and plans are not yet ready for release. Dinner addresses at the time of the release of the report and discussions at preceding meetings, however, pointed to two things of interest. One of these especially emphasized by the President of the A.M.A., Dr. Roscoe Sensenich, was the importance of action at the local level, the formation of community health councils or committees to acquaint themselves and their neighbors with available facilities and resources and the inadequacies. Such stimulation need not wait for either over-all recommendations or financial support; it requires only local interest.

Part of the problem of good medical practice is that of rapid dissemination of newer knowledge to all areas. This phase was emphasized particularly in discussions on continued education, and at these meetings was stressed the necessity for maintaining